were on beta-blockers. Only 3 patients had postop events: 1 MI, 1 death < 30 days & 1 stroke. No patient with normal, IR or high risk MPS and one with the low risk MPS had MI. There was 1 death <30 days and stroke after VS (both in IR-MPS group). Angio was performed in 19 (25%) patients (1 in the low risk, 16 in the IR and 2 in the high risk MPS groups), coronary revascularization in 4 (3 in IR and 1 in high risk MPS patients). In the IR-MPS group, there were no MI, one death <30 days (angio group, n=16) and 1stroke (no angio group, n=25), p=ns.
Conclusion: There is no incremental benefit of routine coronary angiography in elderly patients with intermediate risk myocardial perfusion scans prior to vascular surgery.

1089-142 Short-Term Functional Recovery After Coronary Artery Bypass Grafting in the Elderly

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Background: An increasing number of older patients are undergoing coronary artery bypass grafting (CABG) and little information is available about the short-term functional recovery of these patients.
Methods: We interviewed a prospective cohort of patients undergoing first CABG between 1/99 and 2/01 at Yale-New Haven Hospital both at the time of surgery and at six weeks later. We compared short-term functional recovery among patients, stratifying by age 80 years.
Results: Of the 1170 patients who were enrolled in our study cohort, 112 were 80 years old or older. Compared with younger patients, the older patients were more often female, had less history of diabetes and hypercholesterolemia, and had more history of heart failure, cerebrovascular disease, stroke, and renal failure at baseline. Few major adverse events occurred during the hospitalization and the differences between younger and older patients were not significant. However, at 6 weeks after surgery, the mortality rate was significantly higher for the older patients (3.5% vs. 0.8%, p<0.01). More often older patients were too ill or confused to be interviewed (3.5% vs. 0.7%, p<0.01). On average, physical functioning (as measured by SF-36) score at 6 weeks was 3 points lower than baseline for younger patients and 11 points for older patients (P <0.01). In addition, significantly more older patients had marked deterioration (as defined by >15 points decrease in score) in their functional status than younger patients (48% vs. 34%, p=0.02). The difference remained significant after adjusting for other demographic and clinical characteristics.
Conclusion: Although in-hospital mortality rate after surgery for the elderly was comparable to that of the younger patients, the elderly had a higher mortality rate 6 weeks after surgery and a significantly higher rate of delayed recovery in functional status. Information about short-term recovery may help in clinical decision-making about CABG and in the development of interventions to improve functional status after surgery.

1089-143 Paradoxical Use of Angiography With Advancing Age: Insights From an International Trial Population

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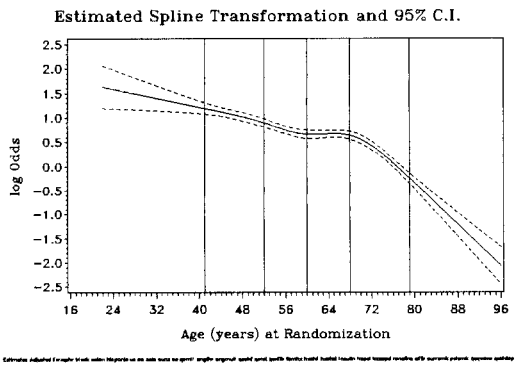
Background: Despite a high risk of cardiac events, elderly pts are reportedly less aggressively managed following ACS. We examined the extent to which pt age is associated with management in a large international ACS population.
Methods: The SYMPHONY trials randomized international ACS pts to an oral IIb/IIIa inhibitor to reduce recurrent cardiac events. Use of cardiac catheterization (CC) and revascularization were not protocol specified. We describe 30-day CC and revascularization in the elderly (≥ 75 yrs; n=1794) vs. younger pts (<75; n=14043) in SYMPHONY after adjustment for baseline factors and across region of enrollment (37 Countries, 7 Regions).
Results: Elderly pts (mean 79 yrs) were more often female, with HTN, DM, prior MI, and CABG but less often smoked. They did not differ in qualifying event (QE) enzymes or EKGs. From QE to 30d, elderly pts underwent less CC (53 vs. 63%) and PCI (28 vs. 37%), but more CABG (8 vs. 7%) vs. younger pts. After adjustment, pt age (younger) and region (US) were significant predictors of 30d CC. The relationship btw age and CC was non-linear (figure), and differed btw US and non-US regions (interaction term p=0.016). Elderly pts were less likely to undergo CC c/w younger pts within the US [adj OR: US= 0.43 (0.35, 0.52) vs. non-US=0.60 (0.51, 0.71)], despite a higher use of CC in the US overall.
Conclusions: Pt age is a strong determinant of referral for CC even after multiple adjustments. This age-related decline is seen across international practice and is greatest beyond age 75.



1089-144 Treatment and Outcome in an Unselected Elderly Population With Acute Myocardial Infarction: Data From the AMI Florence Registry

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Background. Reperfusion treatment (RT) is considered particularly beneficial in higher risk subgroups, including the elderly. Primary PTCA (P-PTCA) is the most frequently utilized modality of RT in the Florence area (Italy). Scanty data exist about the use of P-PTCA and the outcome in an unselected elderly population.
Methods. Data are derived from the AMI - Florence Registry, a prospective observational registry including all the Florence area residents who experienced AMI from March 1, 2000 to February 28, 2001 and were admitted to hospital within 24 h from symptom onset. A preliminary analysis concerning the first 563 patients (pts) with ST-elevation AMI included in the registry is presented.
Results. Of these pts, 281 (49.9 %) were < 70 yrs (Group 1) and 282 (50.1%) were ≥ 70 yrs (Group 2). No difference was observed in time from symptom onset to hospital admission between groups. RT was used in 85 % of Group 1 pts (P-PTCA in 93%) and in 66% of Group 2 pts (P-PTCA in 92%) (p=.001). Of the Group 2 pts directly admitted to the 2 centres with P-PTCA facilities, 89% underwent RT (99% with P-PTCA) while only 49% of the Group 2 pts admitted to the 5 hospitals without invasive facilities were treated with RT (81% with P-PTCA performed after patient transfer) (p=.001). At multivariate analysis age ≥ 70 yrs was negatively associated with the use of RT (OR 0.47, 95% CI 0.30-0.75). In pts not treated with RT, in-hospital mortality was 12% in Group 1and 20% in Group 2 (p=.21); in pts treated with RT, in-hospital mortality was 1.3% in Group 1 (1.4% in P-PTCA pts) and 9.7% in Group 2 (10.5% in P-PTCA pts) (p=.001). At multivariate analysis age≥ 70 yrs was associated with a reduced probability of survival (OR 0.39, 95% CI 0.17-0.90), while the use of RT approached statistical significance as a protective factor in both Group 1 (OR 4.32, 95% CI 0.74-25.4) and Group 2 pts (OR 1.93, 95% CI 0.93-4.0).
Conclusion. Even in a setting where P-PTCA is the preferred modality of RT, elderly pts are less likely to undergo RT, particularly if they are admitted to a community hospital without invasive facilities. The positive effect of RT observed in pts <70 yrs was maintained also in pts ≥ 70 yrs.

1089-145 Predictors of In-Hospital Outcome in Octognenarians With Acute Myocardial Infarction Undergoing Primary Coronary Angioplasty

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Background: Because elderly patients (pts), especially those 80 years of age and older, have been excluded from most studies of primary coronary angioplasty (PCA) in pts with acute myocardial infarction (AMI), in-hospital outcomes in these pts are not well known. The purpose of this study was to determine the predictors of in-hospital mortality in octogenarian or older with AMI undergoing PCA.
Methods: We analyzed consecutive pts who were 80 years of age or older and underwent PCA within 72 hours onset of AMI between Jan. 1991 and May 2000 at Kokura Memorial Hospital. A multivariable logistic regression model was developed to ascertain predictors of in-hospital mortality. Variables with p<0.30 in the univariate analysis were included in the multivariate model.
Results: This study population comprised of 198 pts with a mean age of 84.1 +/- 3.4 years, 51% of male gender, and 40% with anterior wall localization. Pts underwent PCA within 5.1 +/- 4.5 hours from the onset of symptoms and coronary stenting performed in 94 pts (47.5%). The incidence of TIMI 3 flow at the end of PCA was 96.0% and complications associated with PCA occurred in 10.6% (G-I bleeding or puncture site bleeding in 10 pts, stroke in 7 pts, acute renal failure in 2 pts, peripheral vascular embolism in 1 pts and stent thrombosis in 1 pts). Overall in-hospital mortality rate was 10.1% and the clinical success (final TIMI 3 flow without death or complications) was achieved in 153 pts (77.3%). Multivariate analysis revealed that need for IABP (OR 6.93, 95%CI 1.44-33.4, p=0.0158), renal dysfunction (OR 20.0, 95%CI 3.15-127, p=0.0015) and stent use (OR 0.242, 95%CI 0.059-0.988, p=0.048) were significantly independent predictors of in-hospital mortality.
Conclusion: Octogenarinans undergoing PCA could obtain a high rate of final TIMI 3 flow and acceptable clinical success rate, but remained at high risk of complications especially bleeding or stroke. Coronary stenting seems to be important to improve in-hospital mortality in octogenarians with AMI.